Pharmacy NewsCapsule

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This Resident is on an Antipsychotic Medication, Now What?

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Long term care (LTC) surveyors ask themselves this question everyday as part of the LTC survey process. Many of the pharmacy regulations and surveyor guidance from the Centers for Medicare and Medicaid Services (CMS) focus on psychotropic medications, specifically antipsychotic medications. The regulations and guidance can be confusing when applied to very complex and daunting situations.

Over the next few months this newsletter will take pieces of these regulations and simplify them to help LTC surveyors have a clearer understanding.

The first item to explore is the dose reduction requirement. CFR 483.25(l)(2)(ii) states: Residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions unless clinically contraindicated, in an effort to discontinue these drugs.

The key words in the regulation are clinically contraindicated. This phrase basically means that the dose reduction (or any other intervention) would not be appropriate for that patient based on their

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Surveyor Dilemma

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"I'm stuck. My instincts tell me something is wrong. I think there is a deficiency but I cannot prove it." This is a scenario that every surveyor will go through. It is similar to the health care provider who is looking at a patient and feels there is something wrong with them but can not quite put a finger on it. In some cases a healthcare provider can make an educated guess and try something that seems rational and conservative. Health care providers typically will explain their approach and what the next step will be.

In most cases a surveyor cannot make an educated guess. Decisions must be based on relevant findings and facts. If they write a deficiency, it's public record. It may get challenged in court and needs to be defendable. So a surveyor's work must be objective and supported by facts.

When it comes to questions on medications these scenarios are very difficult. Did that medication cause the adverse effects? If they did, was it something that was avoidable? Should the facility have anticipated, monitored and planned for the adverse effect? These are tough cause and effect questions that must be answered. As surveyors our job is to protect patients by assuring health care facilities and assisted living facilities are following specific regulations. The intent is to detect situations where the facilities actions or lack there of, were the cause or could lead to a cause of a negative effect. It is common knowledge that some negative effects are unavoidable, for example, due to the disease of the patient. As a surveyor we need to recognize this and focus on those situations where avoidable negative effects are investigated.

Here are some medication examples that have confused surveyors and health care professionals in the past. Male patient on digoxin 0.125mg every day, furosemide 40 mg every day, lisinopril 20 mg every day, omeprazole 20 mg every day and aspirin 325 mg every day. This patient was comatose, not receiving

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New Drugs

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Brand Name	Generic Name	Use
Entocortec	Budesonide	Capsule for mild or moderate crohn's disease.
Foradil	Formoterol	Inhaler for COPD.
Ultracet	Ultram/Acetaminophen	Tablet for pain.
Spectracef	Cefditoren pivoxil	Tablet; Antibiotic

Med Error Corner

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What can you do today to fight medication errors?

Let's look at a simple intervention. QID vs. QD, TSP vs. TBSP, AU vs. OU. Abbreviations are dangerous. It is simple to read QID four times a day as QD once a day or TSP teaspoon as TBSP tablespoon. These misreads could lead to a 4 time underdose in the QID/QD error or a three time overdose in the TSP/TBSP error.

There are multiple examples cited in the literature of patients being admitted to hospitals, having to be retreated, etc. all because a prescription or treatment order was misread due to the use of abbreviations. This is a well-known problem yet it still occurs mainly because people do not take the time to write out the words.

However take a stopwatch and write TSP and now time it again writing out teaspoon. Probably about a second difference right? Time is an absurd excuse when it involves patient safety.

So what is the intervention to eliminate abbreviations? As surveyors, we should recommend that providers work to eliminate abbreviations in their orders. If citations are issued related to abbreviations then plans of correction should indicate that the facility is implementing a plan to eliminate or clarify all orders that are written using abbreviations.

Focus Drug of the Month

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Lanoxin®; digoxin

This is not a new drug but since digoxin was mentioned in this newsletter I thought it would be a good refresher as it is still used in the elderly and can be a forgotten problem medication.

Digoxin is an oral tablet used to treat congestive heart failure, atrial fibrillation, atrial flutter, supraventricular tachycardia and cardiogenic shock. Most elderly will be on a dose of 0.125 mg daily.

The issues with digoxin involve toxicity. In many cases elderly patients are placed on digoxin and told they will take it for life and then nothing else ever happens again. Very often, however, as we age we are placed on new medications for new problems, we change our diet or we change our activity level. All of these things change how digoxin is absorbed, metabolized, and eliminated from the body.

For example, as we age kidney function may decline, requiring a lower dose of digoxin. Diseases like hypothyroidism can change metabolism and clearance of digoxin.

Does that mean you need to take regular digoxin drug levels? No. In many circumstances drug levels may not tell the entire picture. For example, anorexia caused by digoxin can occur at so called normal drug levels.

Monitoring digoxin for adverse effects is more effective on a regular basis than drug levels.

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condition as it would cause harm.

Just what are situations that are considered clinical contraindications? First the State Operations Manual (SOM) lists ten psychiatric conditions that should not have dose reductions. Anytime you see those diagnoses you would not expect dose reductions. The difficult piece is that the diagnostic verbiage listed in the SOM may not match up nicely to DSM IV diagnostic verbiage that many psychiatric physicians would use. Therefore if you have questions related to situations where a dose reduction may be required, please clarify with the physician, director of nursing, and other staff why the medication is being used, how they are monitoring, etc.

A second clinical contraindication is a patient that has had a history of recurrent psychotic symptoms (delusions etc.) that has been stabilized on a maintenance dose of an antipsychotic drug and is not experiencing significant side effects. A third clinical contraindication is a patient that has had two dose reduction attempts within a year that have failed. In this case subsequent dosage reductions would not be required, however, depending on the clinical diagnoses many physicians may still try dose reductions.

The last clinical contraindication is commonly called physician justification. This specific area usually becomes an area of contention and is in many cases negatively viewed by all participants. In most cases, this stems from the lack of communication or in some cases lack of understanding where to find the pieces of communication. For example, a piece of the justification can come in the form of subjective or objective improvement by the patient. This information may be contained in the behavior monitoring sheets, on the Minimum Data Set (MDS) or in the nursing notes….none of which are typically done by a physician.

The SOM indicates justification should include the following: diagnosis and description of symptoms, why that diagnosis was determined vs something else, why the specific medication was chosen over another intervention, and why that specific dose of medication was chosen. If you look at these pieces often times the information is not recorded in the physician progress notes. You may need to look at the MDS, consult notes, behavior monitoring sheets, nursing notes, activity notes, etc. Also if you look at these items it is not unrealistic that some alternatives were thought about by the physician and ruled out due to obvious reasons. Very often physicians like all health care professionals may not document the obvious. This may not be a good practice as the obvious to one person may not be the obvious to another. However as a surveyor you need to recognize the fact that this does occur and an effort must be made to discuss the issues with the physician and staff involved.

So, as you can see antipsychotic drugs do not always ensure a requirement for dosage reductions. A surveyor determining if a dose reduction is necessary could spend extensive time investigating. This time can be greatly reduced if you understand when the dose reduction is necessary.

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Monitoring for side effects should include anorexia, nausea, vomiting, visual changes, weakness and confusion. Beyond monitoring for side effects, all new drugs and their effect on current medications must be considered. Many medications may affect digoxin metabolism or excretion leading to negative effects.

At the American Medical Directors Association annual symposium Richard Ackermann, MD, Professor of Family Medicine at Mercer University School of Medicine addressed discontinuing unnecessary medications. Dr. Ackermann specifically recommended that digoxin, because of its side effects, can be a good drug to discontinue. Be aware however that digoxin should not be discontinued abruptly and during discontinuance the patient must be monitored closely.

Advantages of discontinuing medications can include elimination of medication-related adverse effects, freeing staff for other duties, and savings of about $1 per day in nursing staff time per drug discontinued. Candidates for possible discontinuance include digoxin, diuretics, and preventive medications like nonsteroidal antiinflammatory drugs.

So as new drugs become available do not forget about the ones the patient currently is on and consider discontinuing those that no longer make sense. Sometimes the saying “if it isn’t broke don’t fix it” may not make the best sense when dealing with medications.

If there are medications you would like featured here please send an email to Doug at engleda@dhfs.state.wi.us

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or taking fluids or nutrition. He continued to receive all of his medications. Due to his condition he was admitted for palliative care. Upon evaluation his labs suggested there was some dehydration. The furosemide, digoxin, lisinopril and aspirin were all discontinued. Within days this person became alert, drank fluids and ate normally. (This example is cited in *Caring for the Ages July 2001).*

Another example: Resident was admitted to hospital with acute renal failure. Hospital discharge diagnosis was polypharmacy with dehydration. This resident was on 19 medications. Some of these medications had significant anticholinergic or dehydrating effects. This resident also happened to have a urinary tract infection (UTI) two weeks prior to the hospital admission for the acute renal failure. (This example is adapted from a LTC survey in WI.)

In both of these cases, a surveyor who saw the comatose man in the first scenario or was reviewing the history on the acute renal failure scenario may instinctively feel something is wrong and investigate the situation. The surveyor may focus the investigation on the medications to look for cause and effect. In the first scenario hindsight is 20/20. The medications were the cause. Digoxin and furosemide can lead to anorexia and dehydration even at normal levels. This is commonly overlooked in long term care, so is it a deficiency? The deficiency may be apparent if there was a significant change in the patient that was not investigated. Depending on the evidence a possible deficiency may exist from the fact that the facility continued to administer furosemide when the resident was not drinking or eating.

In the second scenario was it the medication that let to renal failure? Was it the resident's condition? Was it the UTI? We will probably never know…so was there a deficient practice? It all depends on the facts. For example, if this person was not eating or drinking and all medications continued to be given then there may be a deficiency.

The point that must be driven home is that as a surveyor you may have a lot of information that is provided in hindsight or in some cases your clinical experience may identify situations that a provider may not yet have thought about. In many cases you need to put yourself in the time frame that the provider was operating to determine if they were taking action that was rational. Medicine in many respects is a guessing game. Sometimes the initial diagnosis is wrong. That in itself is not a deficiency. Failure to do anything or continuing to do something even when it is causing significant harm are typical situations that will be considered deficiencies.

So remember when your instincts may be telling you something is wrong, be aware of 20/20 hindsight and emotions. Gather the facts and if the facts are not there but you still think something is wrong, share that concern and your observations with the facility and team members. Remember the residents and patients are your main focus.

Consultant's Corner

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This section is basically a miscellaneous section that will show up each issue and will contain tidbits of information, most of which will come directly from your questions. If there is a topic you want more detailed information about, please drop me an email at engleda@dhfs.state.wi.us and I'll see what I can find.

When should insulin be administered?

There has been a lot of new products in the insulin market. Some insulins last 24 hours, others for 6 hours. Administration technique and timing will depend on the type of insulin a patient needs. Regular or short acting insulin is typically given 30 minutes prior to a meal. However some of the new short acting insulins must be given no more than 15 minutes prior to a meal or even immediately prior to eating.

Insulin administration also depends on the patient and the area of administration. An injection in the arm may be absorbed quicker than one in the thigh. Patient individuality may exist as well. In these cases some physicians may expressly order regular insulin to be administered 1 hour before meals for example. In absence of clarified physician's order the recommended manufacturers guidelines for insulin administration should be followed.

References are available upon request.